THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Methamphetamine

Crystal meth and other amphetamine-class stimulants. A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE.** Meth withdrawal will not kill you through seizure the way alcohol or benzodiazepine withdrawal can. But the crash produces one of the most severe psychological states in addiction medicine, and the depression is a genuine suicide-risk window, especially in days 1 to 5.
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> **If you have thoughts of suicide or self-harm, call or text 988, or text HOME to 741741 (24/7).** Call 911 for chest pain, irregular heartbeat, shortness of breath, sudden severe headache, facial drooping or arm weakness, a seizure, a body temperature above 104°F, or paranoid delusions and hallucinations you cannot reason your way out of. Meth-induced psychosis can persist for days to weeks after last use.
>
> SAMHSA: 1-800-662-4357

1. Before you start

This is a route through the Recovery Kernel for people recovering from methamphetamine, and for the people supporting them. The Kernel's frame: what happened was not weakness. Your brain has a specific genetic architecture that made stimulants feel necessary, and meth solved a real neurobiological problem while destroying everything else. Five rules set the order of everything that follows.

- **Take the crash as seriously as a physical withdrawal.** The danger is not seizure. It is the depth of the depression, and the heart and psychosis risks that come with use. Do not go through days 1 to 5 alone if you can avoid it.
- **Screen for psychosis risk before anything else.** If you have a personal or family history of psychosis, schizophrenia, or bipolar disorder, the Kernel calls further meth use a genuine contraindication, not a risk to weigh.
- **The timeline is long.** Acute misery resolves in weeks, but substantial D2 receptor recovery takes 12 to 17 months. Knowing that in advance is itself harm reduction: it changes what a flat month four means.
- **Design recovery for the brain you have.** For the Warrior profile, a calm, quiet life will never feel like enough. The route builds real intensity, not just rest.
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supplemental Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The two core chapters are Chapter 11 (How to Recover from Methamphetamine and Amphetamine-Class Stimulants) and Chapter 32 (Discontinuance Protocol: Methamphetamine). Chapter 11 also covers prescription stimulants (Adderall, Vyvanse, Ritalin), MDMA, and cocaine, and treats them as the same biology. Chapter 29 covers chemsex. Section numbers (§) refer to sections inside those chapters.

> **A note on protocol numbers.** Supplemental Chapters 11 and 32 cite Compendium protocols by number, and some numbers do not match the Compendium as printed. They call Protocol 09 "Sleep Architecture" (printed: The Gut-Brain Axis; sleep is Protocol 17), Protocol 05 "environmental redesign" (printed: Digital Detox), Protocol 06 "Daily Structure" (printed: Phenotype Assessment), Protocol 13 "trigger mapping" (printed: The Pharma Trap), Protocol 20 "identity reconstruction" (printed: Mapping the Terrain), Protocol 16 "family and relationship repair," and Protocol 22 "community rebuilding" (printed: The Family Field). This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> For methamphetamine, the sharpest version is using again specifically to stop the come-down — the crash is the expected other half of the peak, not proof the drug stopped working.
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> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: suicide risk, heart, psychosis, use level. Screen for the psychosis-risk profile.	Supp. Ch. 32 §§0, 6, 7 Supp. Ch. 11 opening Main Book, Quick-Start Step 1
1	Days 0–14	Ride out the crash, the Pit, and the Gray. Do not be alone. Avoid what makes it worse.	Supp. Ch. 11 §3 Supp. Ch. 32 §§2–4 Compendium P01
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3

Step	When	What you do	Turn to
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs.	Supp. Ch. 5 Step 1 Supp. Ch. 11 §2 Compendium P06
4	Weeks 2–6	Resolve your combined profile. Ask about ADHD.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 11 §2; Ch. 32 §6
5	Day 1 to Month 6	Build the biological foundation: methylation, dopamine, receptors, sleep.	Supp. Ch. 11 §§4–5 Supp. Ch. 32 §8 Compendium P18, P07, P17, P09
6	Weeks 1–12, then ongoing	Craving interrupt. Cue redesign. Name the transfer risks.	Supp. Ch. 11 §4.4, §7 Compendium P02, P05, P20, P21, P08
7	Weeks 2–24	The Recast: function audit, replacement map, weekly architecture.	Supp. Ch. 11 §6 Supp. Ch. 32 §5 C-28; Compendium P19, P03, P29
8	From week 1	Ask about medication, psychiatric support, and ADHD.	Supp. Ch. 11 §8 Supp. Ch. 32 §8, §9 Supp. Ch. 38; Compendium P13
9	Months 1–12+	Identity, relationships, inventory, work.	Supp. Ch. 42, 43, 39, 51 Compendium P24, P22, P16, P25
10	Year 1 to Year 10	Steward: review, transplant, guide others. A break is not a reset.	Supp. Ch. 44, 6, 38 Supp. Ch. 32 §3 Compendium P02, P13

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Know the emergency signs in the banner, and know that a stroke or heart attack is a real risk after heavy stimulant use. The Kernel classifies use in four levels. Low (occasional, oral or occasional insufflation, under a few weeks) can usually stop alone with a support contact. Medium (regular, not in extended binges) needs support and the supplement stack from day one. High (multi-day binge-crash cycling for months) means medical support during the crash is strongly advised, especially for the suicide-risk window in days 1 to 5. Chronic, especially smoked or injected (the route with the fastest, deepest spikes), means full medical and psychiatric support during the crash, and formal treatment engagement, not a purely self-directed protocol.

Screen for the contraindicated profile. The Kernel names one combination for which the danger cannot be fully reduced: COMT Met/Met (slow clearance, an anxious, overstimulated baseline) together with a personal or family history of psychosis, schizophrenia, or bipolar disorder. Ask honestly: is there a family history of a psychotic episode of any kind; have you ever, on any substance, lost your grip on what was real; do you run overwhelmed by ordinary levels of stimulation; has a clinician ever raised a mood or psychotic-spectrum disorder? A yes on the history questions with the Met/Met pattern means seeking a psychiatric evaluation before any further use. A reasonable thing to say to a doctor: "I want to understand my personal psychosis risk before I use this again." Note that severe sleep deprivation alone can cause brief dreamlike intrusions into waking, which is not psychosis by itself, but paranoid delusions or a break from reality testing are an emergency.

If the stimulant is prescribed. The Kernel treats Adderall, Vyvanse, and Ritalin as the same biology: the dopamine disruption is real regardless of the prescription. Any change to a prescription belongs in a conversation with your prescriber (Compendium Protocol 13).

Turn to: Supp. Ch. 32 §0 (immediate safety), §6 (the genetically contraindicated profile; how to identify it), §7 (use-pattern classification). Supp. Ch. 11, opening emergency box. Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — The crash, the Pit, and the Gray (Days 0–14)

The Kernel gives the timeline in advance because knowing it changes what the misery means. Hours 0 to 24, the crash: extreme exhaustion, hypersomnia, hunger, depression. Do not fight it. Sleep, eat, hydrate. Days 1 to 5, the Pit: dopamine at the floor, severe depression and anhedonia, intense cravings. This is the highest relapse risk and the highest suicide-risk window in the guide. Do not be alone if you can help it, walk outside daily, and text 988 if it becomes a crisis. Days 5 to 14, the Gray: persistent flatness, low motivation, insomnia, cognitive fog, cravings triggered by people and places. Begin light exercise, which is the repair signal, and start avoiding triggers.

What makes it harder, and is avoidable: high-sugar food, caffeine and alcohol, nicotine and other stimulants, screens late at night and inconsistent bedtimes, dehydration and skipped meals, and prolonged isolation. Exercise is the exception to the caution: more of it, as capacity allows. Anhedonia is worth naming: it is like watching your own life through glass. It has a name and a timeline, and it is not you.

Turn to: Supp. Ch. 11 §3 (the withdrawal timeline; PAWS). Supp. Ch. 32 §2 (timeline), §4 (what you will most likely experience; what makes it harder), §10 (emergency recognition). Compendium Protocol 01, Emergency Triage.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are physically stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the Warrior profile is the primary meth vulnerability), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still using → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning), which includes Case 05, the meth case, and sets your expectations. Supp. Ch. 3 (The Addict Virgin Problem), whose own example is 10 years of methamphetamine use, and which recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

For meth, the critical gene is **COMT** Val158Met. Next come **DRD2/ANKK1** (Taq1A: an A1 carrier has roughly 30 to 40 percent fewer D2 receptors, which the Kernel calls the single most important target for the receptor-rebuilding supplements), **DRD4** (the 7-repeat allele, novelty seeking and ADHD overlap), **DAT1/SLC6A3** (the 10-repeat allele, faster clearance), **MTHFR**, **MAOA**, **BDNF** Val66Met, and **CYP2D6/CYP2B6** (bupropion is CYP2B6-metabolized). Add **GABRA2**, which governs how easily you can interrupt an impulse once it is in motion. Until results arrive: did stimulants make you feel normal, focused, and alive in a way nothing else did; did you use to perform; did you start with a prescription and escalate; do you struggle with flatness even when clean?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 11 §2 (DNA panel for stimulant recovery; reading your profile before you have results). Supp. Ch. 32 §6 (genetic cross-reference). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your combined profile (Weeks 2–6)

Write your profile down and carry key results on a card. How the crash feels differs by COMT profile, which is worth knowing in advance.

If your result is...	What changes	Source
COMT Val/Val (Warrior)	The primary meth vulnerability: a fast-clearing, intensity-seeking system. The crash is mostly profound flatness and boredom, and cravings center on wanting to feel anything intensely. Needs genuine high-intensity outlets.	Supp. Ch. 11 §2; Ch. 32 §6
COMT Met/Met (Sage)	The crash carries more anxiety, rumination, and agitation on top of flatness, with more hypervigilance and harder sleep loss. Stimulants can act as performance enhancement or an escape from overthinking.	Supp. Ch. 11 §2; Ch. 32 §6
COMT Met/Met plus psychosis history	The Kernel's contraindicated profile. Psychiatric evaluation before any further use.	Supp. Ch. 32 §6
DRD2 A1	Reward Deficiency Syndrome. You were born needing more stimulation than average. Build several dopamine sources, never one.	Supp. Ch. 11 §2; Ch. 5 System 5
DRD4 7-repeat / DAT1 10-repeat	Novelty seeking, impulsivity, ADHD overlap. Recovery must include novelty and challenge. Ask about an ADHD evaluation.	Supp. Ch. 11 §2
MTHFR variants	5-MTHF is non-negotiable foundation. Folic acid does nothing if you cannot convert it. Start low: rapid methylation can cause transient anxiety.	Supp. Ch. 11 §2, §4.1; Main Book Ch. 2
MAOA and BDNF Met	High MAOA activity is linked to impulsivity and severity. BDNF Met carriers may need higher exercise intensity for the same repair signal. Exercise is not optional.	Supp. Ch. 11 §2; Ch. 32 §6
GABRA2 high-risk	A thinner braking system: the gap between craving and action is shorter and harder to widen through willpower. A hardware difference, not a character one.	Supp. Ch. 32 §6; Supp. Ch. 4
CYP2D6 / CYP2B6	Poor metabolizers risk toxicity from bupropion at standard doses. Ultrarapid metabolizers may get no effect. Tell your prescriber before starting anything.	Supp. Ch. 11 §§2, 8

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 11 §2. Supp. Ch. 32 §6. Main Book Ch. 5 and Appendix A.

Step 5 — Build the biological foundation (Day 1 to Month 6)

The Kernel's framing: build the floor before the house. It has four parts. First, the methylation foundation (5-MTHF, methylated B12, active B6, magnesium, zinc), because your brain cannot make dopamine, serotonin, or norepinephrine without it. Second, the dopamine precursor stack, but not too early: the Kernel says to wait until you are eating regularly and acute withdrawal is stabilizing, because precursors on an unstable system can worsen anxiety. Chapter 11 says day 5 to 7 at minimum and Chapters 29 and 32 say day 3 to 5, so start later if you are anxious. Third, receptor rehabilitation: a membrane-building stack aimed at D2 density, and NAC, which the Kernel calls one of the highest-evidence supplements for meth, with lion's mane and rhodiola as supports. Fourth, sleep, which the Kernel says is not recovery's side benefit but the recovery itself: meth suppresses melatonin, destroys REM, and damages circadian machinery for months.

The dose tables are in the chapters below. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape). The peptide layer in Supp. Ch. 11 §4.5 is labeled by the Kernel as research compounds needing physician discussion; Dihexa is described as very active with limited human data, so it is not a self-start step.

Turn to: Supp. Ch. 11 §4.1 (methylation), §4.2 (dopamine precursors), §4.3 (receptor rehabilitation), §4.5 (peptides, physician only), §5 (rebuilding sleep). Supp. Ch. 32 §8 (recovery protocol, Tiers 1 and 3). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), Protocol 07 (Neuroplasticity), Protocol 09 (The Gut-Brain Axis), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — Cravings, cues, and addiction transfer (Weeks 1–12, then ongoing)

A craving is a neurological event, not a moral failure. The Kernel's five-minute interrupt: locate it in the body and name where it sits; four cycles of 4-7-8 breathing; change your physical environment, because the cue-response circuit needs the cue environment; make contact with one person, because cravings thrive in silence; do your highest-intensity micro-reward; then document trigger, intensity, action, and outcome. Cravings peak at 15 to 20 minutes and subside, so the only time unit that matters is the next twenty minutes. Cue reactivity for stimulants is among the strongest in addiction medicine, so environmental redesign is high priority.

Name the transfer risks now. The Kernel says Warrior COMT brains will seek stimulation elsewhere, and that gambling, sexual compulsion, and risk-taking are the most common transfer targets. Two common substitutes for early recovery deserve caution: caffeine, which can undermine the sleep that repair depends on, and alcohol as a sleep aid, which suppresses REM and risks a second dependence. Neither is framed as a moral failure, but neither is a neutral bridge.

Stigma is real. People with methamphetamine use disorder report, and provider-bias research confirms, worse care and more dismissive treatment. It does not mean hiding the history that keeps you safe. Addiction-medicine specialists and harm-reduction-oriented clinics generally carry less of that bias. You are allowed to ask for a different provider.

Turn to: Supp. Ch. 11 §4.4 (the craving interrupt) and §7 (the protocol map; the addiction-transfer warning). Supp. Ch. 32 §3 (the two common substitutions), §9 (on stigma). Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer), Protocol 20 (Mapping the Terrain), Protocol 21 (Reading the Collapse), Protocol 05 (Digital Detox), Protocol 08 (Social Environment), Protocol 33 (The Boundary Architect). If meth was part of chemsex: Supp. Ch. 29.

Step 7 — The Recast: same engine, different address (Weeks 2–24)

You cannot remove the drive. The compulsive intensity, the capacity for obsessive focus, and the willingness to sacrifice everything for the thing that matters are the engine meth ran on, and the Kernel calls them your most powerful asset. Its exercise has three assignments. The Function Audit: what did meth actually provide (energy, focus, confidence, social ease, sexual performance, escape, sixteen-hour workdays)? Every item is a need that did not vanish. The Replacement Map: match each function to a natural source, ruthlessly, because "a gentle walk" does not replace "feeling powerful and invincible." The Architecture: design a week with a daily high-intensity physical challenge, an activity with a mastery curve you are climbing, a socially staked connection, a creative or building project with a visible outcome, and an act of service larger than yourself. It is a dopamine architecture, not a hobby schedule.

If your use began or escalated to sustain overwork (long shifts, several jobs, caregiving on top of a full workday), the recovery task includes resolving the overwork itself. Rebuilding a dopamine system while returning to the same unsustainable schedule is rebuilding into the conditions that broke it.

Turn to: Supp. Ch. 11 §6 (porting the addiction; the natural dopamine architecture; the three assignments). Supp. Ch. 32 §5 (the work-driven use pattern). Centurian Paper C-28 (The Recast). Supp. Ch. 36 (Roots and Reversal). Supp. Ch. 3 (timeline recalibration). Compendium Protocol 19 (The Body in Motion), Protocol 03 (Sonic Architecture), Protocol 29 (The Peacetime Paradox).

Step 8 — Medication, psychiatric support, and ADHD (from week 1)

There is no FDA-approved medication for methamphetamine use disorder, which the Kernel calls a genuine gap. What exists: bupropion (modest craving evidence; check CYP2B6 first); naltrexone (may blunt stimulant euphoria, strongest in OPRM1 A118G carriers); modafinil or armodafinil (cognitive improvement and fatigue in early recovery); mirtazapine (emerging evidence from several trials, useful if meth was managing depression); and topiramate (craving reduction, but it can cause cognitive slowing, so monitor closely in a brain already recovering). A psychiatric evaluation during the crash is proportionate if depression is severe, given the suicide-risk window.

If you ask whether you have ADHD (the fog of early recovery can resemble it, and sometimes real, undiagnosed ADHD was part of what made stimulants compelling), that is worth a psychiatrist's time. The Kernel also describes "ghost scaffolding," a time-limited, specialist-supervised long-acting stimulant used to bridge the executive-function gap in some addiction-medicine programs. It rates this Emerging evidence, debated, and not a self-directed strategy, and it is not a license to self-medicate with any stimulant.

Turn to: Supp. Ch. 11 §8 (medications your doctor may offer). Supp. Ch. 32 §8, Tiers 2 and 2.5. Supp. Ch. 38 (questions to ask about medication duration). Compendium Protocol 13 (The Pharma Trap).

Step 9 — Identity and rebuilding a life (Months 1–12+, revisited later)

The stimulant user's identity is often built around the speed, productivity, and capability the drug provided, so the central question is who you are without the chemical performance boost. Meth typically devastates relationships, and isolation is where relapse incubates. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Trauma-informed work belongs after biological stability, and the Kernel notes chronic hypervigilance channeled into forced achievement is a documented trauma-driven pathway into stimulant use.

Turn to: Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Compendium Protocol 24 (Returning to Work), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral), Protocol 23 (Rebuilding the Ledger), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 10 — The long game, and why a break is not a reset (Year 1 to Year 10)

The Kernel maps the first year to a year and a half in detail and does not project beyond that. Navigation after that shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02. Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

The Kernel is explicit that "a year off, then I will know how to use safely" is only partly right. Receptors do recover on a measured timeline, but tolerance is genuinely lost, and returning to a familiar amount is dosing a body whose capacity has changed, which is the mechanism behind elevated cardiac and overdose risk in relapse after abstinence. The old pathways are quieter, not deleted, so relapse after a break can escalate faster than the original use did. The neurons are the same cells you had before; the task was never erasure, but building competing pathways strong enough to win.

Turn to: Supp. Ch. 32 §3 (how long until the brain is back to normal; "the fracture"; the cell-replacement myth). Supp. Ch. 36 (Roots and Reversal).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	Heart, mood, and psychosis check	Off-label medications reviewed [1]	Annual cardiac and mood check	No known amount; heart risk stays [7]
Biology and genome	COMT, DRD2, DAT1; methylation base	Retest labs; step stack to upkeep [2]	Prescriber card: COMT, CYP2B6	Re-check with new meds and age
Cues and environment	Cue removal; daily structure	Cues fainter, not gone	Triggers shift: work, stress [5]	Same plan, rehearsed
Intensity architecture	Exercise daily; BDNF repair	Mastery ladder carries the load [3]	Several intense outlets	Intensity outlets, still weekly
Sleep and mood	Crash, Pit, Gray; sleep rebuilt	Flat days rare; sleep restored	Mood plan, clinician-led	Stress plan, sleep habits
Identity, work, load	Function audit; overwork audit	Inventory; return to work, paced [4]	Sober community established	Annual re-inventory
Meaning and Manning	Purpose: first seeds only	The Recast: a new address	Manning: guide for others [6]	Mentor or run a group

The seven shifts

1. **Year 3, off-label medications are reviewed.** The Kernel offers no approved drug, only off-label options to discuss with a prescriber (Supp. Ch. 11 §8). By year 3, review whether each is still needed and what marks readiness to stop, using the standard in Compendium Protocol 13, and keep the cardiac follow-up that your history calls for.
2. **Year 3, the stack moves from building to upkeep.** Substantial D2 receptor recovery takes 12 to 17 months (Supp. Ch. 32 §3), so by year 3 the receptor-rebuilding work has largely done its job. Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, the mastery ladder carries the load.** The Kernel's replacement for meth is a portfolio of natural dopamine sources with a mastery curve that keeps moving (Supp. Ch. 11 §6). By year 3 that architecture is ordinary life, not an emergency tool, and keeping several outlets guards against single-source fragility for a DRD2 A1 profile.
4. **Year 3, work is rebuilt at a sustainable load.** If overwork drove your use, this is when returning to work (Compendium Protocol 24) tests whether the new

structure holds. Rebuilding into the same unsustainable schedule is the failure the Kernel warns about (Supp. Ch. 32 §5).

5. **Year 5, triggers shift from cues to context.** As acute cue craving fades, what remains is what the Kernel names as PAWS triggers: high stress, poor sleep, illness, significant emotional events, and, for work-driven use, the pressures that made the drug attractive (Supp. Ch. 11 §3; Ch. 32 §5). Keep Protocol 21 ready.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). The Kernel says many people in stimulant recovery find their most stable natural high in becoming guides for others on the same path (Supp. Ch. 11 §6.2).
7. **Year 10, no known amount, and the heart risk stays.** The Kernel says a long break does not reset tolerance or the speed at which old pathways reactivate. Any return to a familiar amount is where cardiac and overdose risk concentrates (Supp. Ch. 32 §3). Keep cardiac and mood checks on your calendar.

What is sourced and what is extrapolated. *Shifts 3, 6, and 7 rest directly on Kernel text. Shifts 1, 2, and 4 apply Kernel rules at a timing chosen for this guide. Shift 5 is an extrapolation, partly sourced. The Kernel's detailed meth timeline ends at a year and a half, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years, with meth's dopamine-terminal damage improving but possibly not fully. Years 3, 5, and 10 are therefore projections.*

5. What outcome to expect

The short version

If you do the route above, with triage and the psychosis screen first, the crash ridden out with support, the biological foundation, cues and transfer risks handled, the Recast built into a real weekly architecture, and medication and ADHD questions raised with a physician, this is the outcome the Kernel projects:

- **You get through the crash and the Pit.** The acute crisis resolves in weeks. Cravings shift from constant to episodic or cue-triggered by weeks 2 to 4.
- **By day 90, the neuroplasticity window closes.** With consistent exercise, sleep, and the other inputs, dopamine receptor density is significantly improved, gray matter volume measurably increased, and cravings dramatically reduced for most people.
- **By months 3 to 12, mood is near baseline for most,** cravings are mostly contextual, and cognitive function is largely restored. Substantial D2 receptor recovery takes 12 to 17 months.
- **By year 1 to 2, meth "feels like a chapter in your history rather than a current story,"** in the Kernel's words. Some structural damage may improve without fully returning to the pre-use baseline, and the goal is an optimized post-recovery baseline, not the past.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk or that a return to use cannot happen. It states that the crash is a suicide-risk window, that there is no approved medication, that a break is not a reset, and that flat days at month 4 are expected, not evidence of failure.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
The crash	Hours 0–24	Extreme exhaustion, hypersomnia, hunger, depression. Not a medical emergency on its own. Sleep, eat, hydrate.	Supp. Ch. 11 §3; Ch. 32 §2	Clinical timeline
The Pit	Days 1–5	Severe depression and anhedonia. The highest relapse and suicide-risk window. Do not be alone if avoidable.	Supp. Ch. 32 §2	Clinical timeline
The Gray	Days 5–14	Persistent flatness and fog. Begin exercise. Start avoiding triggers.	Supp. Ch. 11 §3	Kernel projection
The Slow Return	Weeks 2–4	Cravings episodic, not constant. Sleep stabilizing. First meaningful behavioral goals become realistic.	Supp. Ch. 32 §2	Kernel projection
Neuroplasticity window	Days 31–90	New pathways form, then consolidate by day 90. D2 density significantly improved; gray matter measurably increased; cravings dramatically reduced for most.	Supp. Ch. 32 §3	Kernel projection
PAWS	Months 1–18	Episodes of sudden depression, craving, and fog, lasting hours to days, triggered by stress, poor sleep, illness, or cues. Not relapse.	Supp. Ch. 11 §3	Kernel projection
Near-baseline	Months 3–12	Mood near baseline for most. Cravings mostly contextual. Cognitive function largely restored.	Supp. Ch. 11 §3; Ch. 32 §2	Kernel projection
Substantial D2 recovery	12–17 months	The deepest layer of repair. The Kernel notes closer to a year and a half than a season.	Supp. Ch. 32 §3	Kernel projection
Deep-root reversal	2–5+ years	Some dopamine-terminal damage improves but may not fully return to baseline. The target is an optimized post-recovery baseline.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Purpose and service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's own 12-month numbers for one meth profile

Supplemental Chapter 2 gives projected outcomes at 12 months for an adherent protocol compared with standard treatment. Case 05 is a 26-year-old who grew up with ADHD that was never properly treated. Meth made her feel, for the first time, focused and capable. She has used for four years and now uses to feel normal. Her profile is MTHFR C677T T/T plus COMT Val/Val. The Kernel calls this the profile where it earns its claim: for the first time, every failing system gets a matched intervention.

Case	Measure	Kernel protocol	Standard treatment
Case 05	12-month abstinence with full biological support and ADHD treatment	62%	15%
Case 05	Functional improvement (work and relationships) at Month 6	73%	25%
Case 05	Craving reduction of 50% or more at Month 3 with the full dopamine stack	67%	10%
Case 05	ADHD symptom management without stimulant misuse	75%	20%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol, drawn from cited studies and NIDA and SAMHSA baselines. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. Case 05's protocol sequences its taper after a foundation is measurably established and includes proper ADHD treatment and a bupropion bridge with a prescriber, so the result is not supplements alone.*

What changes the outcome

- **Going through days 1 to 5 alone.** The crash is a suicide-risk window. Reach out early.
- **Ignoring psychosis risk** when there is a personal or family history of psychosis or bipolar disorder, or when paranoid delusions or hallucinations appear.
- **Ignoring chest pain or stroke signs,** or dismissing a very high body temperature.
- **Caffeine or alcohol as a fix for fatigue and sleep.** They undermine the sleep that repair depends on, and alcohol risks a second dependence.
- **Starting the precursor stack too early,** which can worsen anxiety on an unstable system.
- **A calm-life prescription for a Warrior.** Rest-only plans fail by understimulation. Exercise is the repair signal, and the route needs real intensity.
- **Untreated overwork.** Rebuilding into the schedule that helped create the dependence.
- **Unnamed transfer risks:** gambling, sexual compulsion, risk-taking.
- **Hiding your history from clinicians,** because of stigma. An accurate history matters for your own care, and you can ask for a different provider.
- **"A year off, then I will know how to use."** Tolerance is lost and the old pathways return faster than they formed.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also a cardiac-risk event. Do not use alone, and call 911 for chest pain or psychosis.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the cardiac and psychosis risks of meth, the suicide-risk window of the crash, and tolerance loss after abstinence are well-established clinical concerns. The Kernel itself states that there is no FDA-approved medication, rates bupropion as modest evidence, mirtazapine as emerging, and ghost scaffolding as Emerging and debated. NAC is called one of the highest-evidence supplements in the stack. The rest of the supplement stack, the peptide layer (including Dihexa, which the Kernel notes has limited human data), the percentage projections, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- An honest account of your use: form (prescription stimulant, smoked, injected, insufflated), how often, how long, whether it was work-driven, and whether it was part of chemsex. The Kernel says this is what lets a provider give you real care.
- Any personal or family history of psychosis, schizophrenia, bipolar disorder, or heart conditions. If you are in the crash and the depression feels like more than you can get through, say so today.
- Your COMT, DRD2, DRD4, DAT1, MTHFR, and CYP results, and any ADHD symptoms so an evaluation can be arranged.
- A direct question about bupropion, naltrexone, modafinil or armodafinil, mirtazapine, and topiramate, including how long each would be used and what marks readiness to review it.
- Every supplement you take, with doses, so interactions can be checked.